

# Women's Health Partners, LLC

Diplomates of the American Board of Obstetrics & Gynecology  
[www.myobgynoffice.com](http://www.myobgynoffice.com)

## CONSENT FOR INFLUENZA VACCINATION

Patient Name: \_\_\_\_\_

Patient ID#: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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It is the recommendation of Women's Health Partners, the CDC, and the American College of Obstetricians and Gynecologists that all women who will be pregnant during influenza season (October through mid-May) should be vaccinated for Influenza. The risk of serious illness including death is associated with influenza in pregnancy. The ideal time to be vaccinated is October and November, however vaccination is appropriate throughout influenza season.

The intramuscular injection may be used in any trimester. As with any vaccine, serious side effects are rare, and the most common symptoms are usually just soreness and mild "flu-like" symptoms for 8 - 24 hours. The vaccine does not give you a mild case of the flu. Please read the CDC's information packet provided for additional information.

Do not take the vaccine if you have an allergy to eggs or have had an adverse reaction to the vaccine in the past.

Please note: Some insurances require patients to obtain vaccines through their primary care physician. If this is the case, you will not be covered for the vaccine, if you receive it our office.

Although your medical provider and the US Center for Disease Control & Prevention (CDC) feel that the Influenza vaccine is medically necessary, some insurance plans may not yet provide benefits for its coverage. By signing on the line below, you are acknowledging that you have read this form, understand it and choose to have the Influenza vaccine. Your signature also acknowledges that you are financially responsible for fees billed for these services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Account #

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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